DOCUMENT RESUME

ED 209 824 EC 140 338

AUTHOR Gabel, Harris
TITLE An Ecological Framework for Intervention with Young Handicapped Children and Their Families in Rural Areas: The Family, Infant and Toddler (FIT) Project.
INSTITUTION George Peabody Coll. for Teachers, Nashville Tenn. John F. Kennedy Center for Research on Education and Human Development.
SPONS AGENCY Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C. Div. of Assistance to States.; Tennessee State Dept. of Mental Health and Mental Retardation, Nashville.
PUB DATE Apr 81
GRANT G007802932
NOTE 23p.: Paper presented at the Annual International Convention of The Council for Exceptional Children (59th, New York, NY, April 12-17, 1981, Session F-95).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Demonstration Programs; Extended Family; Infants; *Inservice Education; Intervention; *Mental Retardation; Nuclear Family; *Parent Education; *Rural Education; Young Children
IDENTIFIERS *Family Infant Toddler Project; Tennessee

ABSTRACT

The paper describes the Family, Infant and Toddler (FIT) Project, designed to provide educational and supportive services to rural middle Tennessee families with young mentally retarded children. Noted are the project background (including sporadic outreach efforts) and conceptual orientation, and an ecological perspective which stresses the role of both the nuclear and extended family. Project goals include development of a demonstration service program, developing a replicable inservice training program for local professionals, and expanding educational services to young retarded children in rural areas. Program implementation has involved providing screening and evaluation services and a weekly 3 hour educational clinic for 21 children (mean age 17 months) and their parents in three locations. Clinic activities include group parent-child training, individualized parent-child training, home planning, and a parent-family training and discussion group. Additional clinics are offered periodically to involve members of the child's extended family. The inservice training programs for 23 local allied professionals in the three communities involve a 9 month program in 4 week cycles consisting of two half day seminars in the local community, a day of centralized training activities, and a half day practicum locally. The FIT project staff are also using the media to make the public more aware of the needs and resources available for young retarded children and providing technical assistance to local agencies. Continuation of the program through state, local, and private support is seen as evidence for its effectiveness. (DB)

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.
Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED209824

An Ecological Framework for Intervention with Young Handicapped Children and Their Families in Rural Areas: The Family, Infant and Toddler (FIT) Project

Harris Gabel, Ph.D.
Department of Psychology and Human Development
George Peabody College of Vanderbilt University

Paper presented as part of symposium, "Intervention Approaches for Young Handicapped Children in Rural Areas," 59th Annual International Convention of The Council for Exceptional Children, New York City, April 1981

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Harris
Gabel
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)"

EC140338

An Ecological Framework for Intervention with Young Handicapped Children and Their Families in Rural Areas: The Family, Infant and Toddler (FIT) Project

Harris Cabel

George Peabody College of Vanderbilt University

The Family, Infant and Toddler Project, or FIT Project addresses the problem of providing educational and supportive services to rural families with young mentally retarded children. This paper describes the FIT Project model as it was planned and implemented during its first two years. The paper emphasizes the guiding principles, goals, and major components of the project.

There are many obstacles to providing effective social, medical, and educational services to retarded persons in rural communities. Faced with a scarcity of specialized professional personnel, geographic isolation, and low density and dispersion of target populations, rural communities must find specialized ways of delivering these services. The FIT Project has developed a model program for educating young retarded children and supporting their families in rural areas.

Project Background

The difficulties in providing services for rural retarded children nationally are reflected in Middle Tennessee. The problems became apparent to agencies serving this population. Since 1972, the Early Developmental Assistance Program at the Experimental School of The John F. Kennedy Center for Research on Education and Human Development, George Peabody College, has provided educational programming for preschool retarded children using the model described by Bricker and Bricker (1975). Emphasizing parent training and the integration of handicapped and nonhandicapped youngsters, the center-based Early Developmental Assistance Program included, in 1977, weekly educational clinics for infants, half day programs for preschoolers and toddlers, and a full day preschool program. As a major regional resource for

these services, the Experimental School began receiving requests for assistance from professionals and families in the rural communities surrounding metropolitan Nashville. The staff responded by developing a modest outreach program. Periodic home visits were made to five families with retarded children in a rural community 75 miles southeast of Nashville. Additional outreach efforts included consultation to other early intervention programs with the goal of enhancing their capacity to provide educational services for young retarded children.

These modest efforts were insufficient for the task. It became clear that a greater and different kind of program was required to begin to meet the the needs of young retarded children in Middle Tennessee. Viewing the problems and resources in Middle Tennessee as representative of the situation in similar regions elsewhere in the nation, the FIT Project was created in 1978 to provide a model for meeting the educational needs of young retarded children in rural communities. The FIT Project is a "First Chance" project supported by the Office of Special Education, U. S. Department of Education with matching funds supplied by the Tennessee Department of Mental Health and Mental Retardation.

Conceptual Orientations

The FIT Project is guided by an ecological perspective. In this framework, children are viewed as functioning and developing as parts of social systems (Hobbs, 1966). Thus, young mentally retarded children are conceived as embedded in nuclear families, that is, parents and their children, and parts of broader extended families. Extended families include the extended kinship system, persons related to the nuclear family by blood or marriage, and the informal kinship system consisting of friends, neighbors, and associates (Garrison, Earnshaw, Hood, Frazier, and Crowder, 1975). Both mentally retarded children and their families operate within larger systems in their communities. For these children and families who are frequently in need of specialized human services, the social, educational, and medical service de-

livery systems are particularly salient. The politically active elements of the broader community also become relevant since they influence the quality and availability of required professional services.

The ecological perspective suggests that children and their social systems are interdependent (Holahan, 1977). Changes in one part of systems are assumed to reverberate and have an inpact on other elements. Thus, children can benefit from intervention aimed at their families and communities. In this sense, the targets for intervention include the family and community systems with the child as the central focus within them.

Families and communities, especially the community of local professionals, are seen as important potential resources for young mentally retarded children in rural areas. Consistent with the ecological viewpoint as articulated by Holahan (1977), the FIT Project aims to enhance the competence and potency of families and professionals as they facilitate the development of these children.

Another major theme related to the ecological orientation is the strengthing of linkages between the systems affecting target children (Thompson, 1979). Linkages are mechanisms for coordination and transfer of resources, social support, for example, among systems. Stronger linkages are expected to result in an increase in helpful exchanges among the systems. The project works to build stronger linkages between parents and children, among parents, between professionals and parents, and among local professionals and agencies. But perhaps the best example is the attempt to link extended with nuclear families more closely around the issue of the retarded child. There is reason to believe that these linkages may weaken when a retarded is born.

Caplan's (1976) analysis of the family as a support system provides a basis for understanding ways in which the birth of a mentally retarded child may deprive the parents of needed support from their extended families. According to Caplan, a major function of families is collection and transmission of information about the world. Family members are usually the

beneficiaries of information stored and transmitted by other members of their families. However, while grandparents, for example, may be an important reservoir of information relavant to rearing a normally developing child, they are less likely to be knowledgeable about useful rearing strategies for mentally retarded children.

The extended family is also less likely to provide a constructive ideology, another important support function of families, when mental retardation is identified. A family ideology regarding mental retardation would consist of beliefs, values, and codes of behavior. For some rural families, ideologies may be unsupportive of a nuclear family attempting to rear the retarded child at home and provide an intensive educational experience.

Another supportive function of families is the provision of guidance and practical assistance in dealing with everyday problems. Once again, since the extended family members are less likely to have experience with mentally retarded children than with normally developing children, their ability to support parents by providing guidance and practical may be attenuated.

Finally, families are an important source of support for developing emotional mastery when members face crises. It is well known that a birth of a mentally retarded child commonly precipitates a family crisis (Moroney 1976). Paradoxically, just when parents are experiencing this difficult crisis, their own parents, often eagerly anticipating a normally developing grandchild, may themselves be so upset by the birth of a handicapped child, that they are unable to provide the much needed emotional support.

Therefore, while extended families are potential sources of support in rearing mentally retarded children, their effectiveness may be diminished. The strengthened linkage between extended and nuclear families should lead to increased social support.

Goals and Objectives

The ecological perspective adopted by the FIT Project suggests an in-

tegrated effort aimed at child, family, and community. Discrete goals and objectives have been articulated for these intervention targets. The goals and the activities designed to achieve them are interrelated, so that the overall project is a closely coordinated effort in each community. For clarity and ease of description, the several goals and activities are discussed seperately below.

The first goal of the project is to develop a demonstration service program for young mentally retarded children and their families in predominently rural areas of Middle Tennessee. The objective for children is to provide a family-mediated educational program to enable each child to reach his or her full developmental potential. The project will train and assist nuclear family members, primarily parents, in implementing the educational program for their young mentally retarded children. For extended families, the project objective is to assist them in supporting nuclear families.

The FIT Project's second goal is to increase the pool of personnel qualified to serve the target population by providing training for professionals allied with the enterprise of educating young retarded children and by developing a replicable inservice training program. The major objectives associated with this goal consist of developing and implementing a prototype training program, evaluating and revising the prototype, field testing it and preparing the final product for dissemination.

The third goal is to advance the general expansion of educational services to young mentally retarded children and their families in predominatly rural areas. The objectives for this goal are to increase public awareness and understanding of these children and the potential value of early intervention, to stimulate interest and potential support for additional programs for this population, and to provide technical assistance to local agencies interested in and capable of expanding educational services to them.

Establishing the Program in Rural Communities

In view of the fact that federal support for the project would be limited to three years, ultimate continuation of the program was seen to rest primarily in the hands of state and local agencies. The probability of continuation beyond the period of federal support was thought to be directly related to how the program related to state agencies and, especially, local communities during its operation. The way the program was introduced in rural communities was considered particularly important. This section presents a brief discussion of the approach used to start the project.

The FIT Project established programs in three counties in the first year using the following criteria. Sites were sought within reach of at least five eligible children. The communities selected for the project also had agencies and professionals who would be interested in participating in the allied professional training program with a view towards sustaining services over the long haul. Before selecting a site, it was necessary to be able to identify a physical location for project activities and a local agency willing to assist project clients with transportation.

In the beginning, project staff usually contacted local human service professionals first. The staff operated on the principle that it was essential for local professionals and agencies to share with the FIT Project a sense of responsiblity for the problems of young mentally retarded children and their families. Furthermore, the staff aimed to develop a sense of shared ownership of the project as a solution to some of these problems. Thus, as in process consultation with organizations (Schein, 1969), the FIT Project staff worked to identify and foster a feeling of community ownership of the problems and solutions from the very beginning. These principles have been applied successfuly in initiating programs in other communities (e.g., Strauss and Stowe, 1974).

In the FIT Project communities, local professionals were already keenly

aware of the need to develop addition services for the target population. In general, they had been serving these children and families as well as they could, but they also clearly recognized their own limitations. After hearing a description of the FIT Project, most accepted it as a potentially useful program.

Consistant with the theme of local participation, the staff asked for help from local professionals in finding space for project activities and for transportation for the clients. Local professionals made the necessary arrangments easily in each instance. For example, churches were approached and agreed to house the intervention program for children. Arrangements for transportation were negotiated with exsisting transportation resources in each community. For example, a rural health program agreed to assist in one county.

The active participation of local professionals in the FIT Project was greatly facilitated by meetings held in association with the project training program. Local participants often used training meetings as an opportunity to make addition plans for continuing the project. The staff participated actively and lent support whenever possible. These discussions will continue with a view towards developing additional state and local support for the program.

An education intervention program for children and families and an associated training program for local allied professionals were developed in each county. In November, 1978, the FIT Project began operations in Lewisburg, the county seat of Marshall County, Tennessee. Located approximatly 60 miles south of Nashville, Lewisburg has an estimated population of 18,000 in an area of 377 square miles. The second FIT Project program began operations in April, 1979, in Dickson, Tennessee. Dickson is the major town in Dickson County. It is located approximatly 45 miles west of Nashville. The county population is about 26,000 in an area of 485 square miles. McMinnville, Tennessee, the county seat of Warren County was the

population close to 29,000, Warren County covers 439 square miles located approximatly 75 miles southeast of Nasvhille.

Demonstration Service Program

The development of a demonstration service program is the first goal of the FIT Project. Eligible children referred to the project are screened, evaluated, and enrolled in weekly educational clinics. Operating from a central base at Peabody College, staff members meet with small groups of children and families in or near their own communities to provide the educational clinic program. The following sections describe the services offered.

Project Children

Mentally retarded children are eligible to participate in FIT Project clinics from birth to four years of age. The public schools are responsible for the education of handicapped children from the age of four years (three years for deaf children) in Tennessee. Children can be served in they (a) achieve a score of less than two standard deviations below the mean of the normative population on a standardized test of development or intelligence, (b) have a condition ordinarly associated with mental retardation, Down's syndrome, for example, or (c) evidence moderate to servere functional impairments in four domains such as fine motor, gross motor, and language. Children may be referred by either professionals or parents themselves.

By June 1980, 21 children had enrolled in the FIT Project clinics. Their mean chronological age was 17 months. Based on the administration of the Bayley Scales of Infant Development, these chidren had a mean cognitive age equivalent of 9.0 months. The children were a varied group with conditions including Down's syndrome, microcephaly, cerebral palsy,

hydrocephalus, other neurological damage, and visual and auditory impairments. Eight of the children were multiply handicapped. In general, then, the population actually served by the project was heterogeneous and rather severly impaired. The families had a wide range of socioeconomic backgrounds. Some families had professional parents and others received public assistance.

Screening and Evaluation

When a child is referred, a staff member calls the family to confirm their interest in exploring possible participation. Interested family members are screened in their home. The screening procedure consists of administration of the Denver Developmental Screening Test along with informal observations of the child and family. The services of the project are explained to the families at this time. Children who appear to be eligible on the basis of the screening visit are referred for evaluation and others are referred to more appropriate agencies.

One day psychoeducational evaluations are usually conducted at Peabody College. If necessary to reach the families, the evaluations are completed at the churches housing the project educational clinics. The evaluation includes a family interview, a psychological evaluation, and an educational evaluation. Complete evaluations are scheduled at yearly intervals.

Parents and extended family members are invited to participate in the evaluation and are included in the family interview. The interview elicits information about the child's developmental history, family members' views of the child's current level of functioning, their expectations for their child's future, their major concerns for their child, and the family living conditions and usual pattern of activities. Particular attention is given to sources of stress and availability of support for the parents. Recommendations or referrals for the parents or other family members may result from the interview. For example, one depressed mother with suicidal ideation was referred for psychiatric consultation.[11] Interview data guide the staff

in working with families.

The psychological evaluation consists of the administration of a standardized measure of development or intelligence. The Bayley Scales of Infant Development, Mental Saale and Infant Behavior Record, are used most frequently. Parents are usually present during testing.

The educational evaluation is designed to develop preliminary educational goals and intervention activities. It emphasizes understanding the child's learning process as well as accomplishments attained. The evaluations are based on the procedures described by Griffith (1954) and Uzgiris and Hunt (1975), as well as less formal clinical observations. Each child is assessed in eight domains derived from the branches of development presented by these authors. The same domains constitute the areas of intervention for the educational program. They are gross motor development, personal-social skills, hearing and speech skills, nonverbal communication, eye-hand coordination skills, manipulation skills', cognition skills, and verbal and gestural imitation. Parents also observe the educational evaluation. As a regular part of the educational program, trainers collect this educational data again every three months.

The findings and recommendations are discussed with participating family members at the conclusion of the evaluation. Parents receive copies of the evaluation reports.

Educational Clinics

The weekly educational clinics offer activities for children and support for parents. Served by two staff members designated as infant/family trainers, often with the assistance of a practicant student, each clinic has a capacity of five children and families. Although extended family members are invited to participate in all activities, special evening clinics are held especially for them.

The clinics offer a family-mediated educational program. The strategy of training parents to enhance the development of their young

handicapped children has been used widely with favorable results (see, for example, The Infant, Toddler, and Preschool Research and Intervention Project, The Portage Project, and The Bill Wilkerson Hearing and Speech Program described in Tjossem, 1976). Parents are viewed as the persons primarily responsible for implementing the educational program. The project also aims to develop a sense of peer support among participating parents. The clinic activities described below were designed within this approach.

The weekly clinics are held for three hours and include a variety of activities. These are identified in the sample clinic schedule shown in Figure 1 and described in the following sections. The schedule shows how two trainers work with five parents and children during a clinic session. The participation of allied professional is also indicated.

9:00 - 9:20	Arrival	
9:20 - 9:35	Group Parent-Child Training Parents-Children 1, 2, 3, 4, 5 Trainers A, B	
9:35 - 9:50	Individualized Parent-Child Training	Parent-Implemented Activities
	Trainer A - Parents-Children 1&2 Trainer B - Parents-Children 3	Parents-Children 4&5
9:50 - 10:30	Snack/Home Planning Parents-Children 1, 2, 3, 4, 5 Trainers A, B	
10:30 - 11:00	Individualized Parent-Child Training	Parent-Implemented Activities
	Trainer A - Parent-Child 4 Trainer B - Parent-Child 5	Parents-Children 1, 2, 3
	Trainer A - Parents-Children 1&2 Trainer B - Parent-Child 3	Parents-Children 4&5
11:00 - 12:00	Parent-Family Training/Discussion Group	Children's Group
	Trainer A - Parents 1, 2, 3, 4, 5	Trainer B - Children 1, 2, 3, 4, 5 Allied Professionals

Sample FIT Educational Clinic Schedule

Figure 1

Opening Activities. The clinic begins with a period of informal greeting and discussion among parents and staff when families first arrive. Parents appear to gain support from the staff and from one another as they describe children's progress and other significant events of the preceeding week.

The group parent-child training session is a natural continuation of the arrival period. Parents and children participate in group songs and activities in which each child is recognized and welcomed.

Individualized parent-child training. The purpose of these sessions is to teach parents how to implement activities at home to enhance their children's development. Short term and long term goals for children are selected within the eight intervention domains used by the project. The domains were reviewed above in connection with the educational evaluation. It is critical that parents participate in the selection of goals for children so that the program is responsive to their aspirations for their children. The selection of child goals is guided by the evaluation data and observation of the child and family in their first few clinic sessions.

Trainers demonstrate activities designed to achieve the educational goals and parents select one or two that they agree to carry out at home during the following week. Trainers then assist them as they practice the activities during the clinic. A written description of the activities and a rationale for each is given to the parents on a home activities form developed by the staff. On the reverse side of the form, parents are encouraged to record, day by day, the activities they attempted and their children's progress. These records are the basis of a weekly review of the parents work with their children.

Curriculum activities are drawn from many published sources. To assist trainers in selecting appropriate activities, 89 existing curricula were reviewed in indexed to describe their coverage of the eight project intervention domains.

According to parents' reports, they find the activities suggested for them suitable and actually try to use most of them at home. Twelve of the 20 parents served during the second year attempted at least three-fourths of the activities suggested by the FIT Project staff. Data allowing an evaluation of children's progress in the program is being collected on a continuing basis during the clinic sessions and yearly re-evaluations.

During the snack/home planning time, parents implement educational activities with their children in an actual caretaking context. The parent implemented activities time includes additional practice of the activities. In addition, parents use this time to review materials in the parent library provided for them.

Parent/training discussion group and children's group. The parents training/discussion groups expose parents to general information concerning child development, child rearing, and use of community resources. They also are expected to be a major vehicle for the development of a sense of group support among participants. The sessions are flexible, including formal presentations of relevant topics such as, language development or holding and positioning children. At other times, the sessions are conducted in a discussion format following the model suggested by Auerback (1968) in which parents select the topics for discussion and encourage in mutual sharing of experiences and group problem solving.

The children's group provides additional opportunities for observing the children's behavior. Allied professionals use children's group to practice observation and intervention skills under the supervision of project staff.

A review of the attendance at educational clinics for the second project year revealed that 14 children participated regularly (defined as attending more than 2/3 of sessions schedules for them). Seven participated less regularly. Illness among the child was the major factor contrib-

uting to poor attendance for some families. The attendance data indicate that the clinics enable many rural families to participate in regualr educational activities for their mentally retarded children. At the same time, there are some families who elect to participate only sporadically. Further experience with the clinic model should help clarify the characteristics of families with high and low rates of participation and suggest alternatives for the latter group.

Extended family clinics. Extended family sessions have been scheduled in the evening at six to eight week intervals at each clinic site. In general, the sessions involve extended family members in support of the nuclear family. More specifically, the extended family program is designed to (a) provide factual information to extended family members and inform them about mental retardation so they can communicate with parents on the basis of accurate data rather than folktales, (b) to help extended family members develop a constructive set of ideas, values and attitudes about the retarded child in their family, (c) inform extended family members about ways they can be helpful to parents to retarded children, for example, by providing additional babysitting, and (d) to assist grandparents and other relatives to cope with the frequent emotional crisis surrounding the birth of a handicapped child.

The format of the family clinic parallels the weekly daytime clinics. An arrival time and welcoming activities are followed by a single individualized training session for each family. A family group/training discussion period is also included. Thus, family members are presented with specific information about how to help their child, general information about mentally retarded children and their development. They can learn ways of thinking constructively about mental retardation and working through their emotional reactions to the retarded child in their family. Most importantly, the staff communicates the attitude and expectation that family members will be involved with the care of the child and will help the parents.

Local allied professional training program

The major purpose of the FIT training program is to develop additional specialized professional resources in rural communities to provide educational and supportive services for mentally retarded children and their families as specified in the second project goal. In Middle Tennessee, training activities serve as an important vehicle for ensuring the continuation of the services begun by the FIT Project. The training program will be prepared for dissemination as well, so that it will be available for training professionals in other rural areas. The program and participating local professionals are described below.

The FIT Project training program is aimed at rural professionals who have the potential for increasing the services they provide to the target population. These professional may be identified with a variety of diciplines. Their professional training usually have provided them with some of the concepts and skills necessary to provide services to the young retarded children and their families, but they are currently unable to provide the services because there are major gaps in their expertise. For example, a special education teacher in a local public school can be expected to be familiar with teaching methodology. Few teachers, however, have been exposed to information on handicapped infants during their training. On the other hand, public health nurses may be quite knowledgeable about early child development while having had little systematic exposure to diagnostic-prescriptive teaching approachs for the young handicapped child.

Other considerations are also important for local professionals. Trainees' personal and professional goals should include providing expanded services to young retarded children and their families. It is particularly helpful if trainees are permanant residents of the community with firm local roots and a continuing committment to enhance the quality of life in the area.

Finally, it is absolutly essential that participating local professionals have the support of their agencies for participating in the training program. Ordinarily, trainees will be employed by human service systems whose mission and goals include providing services for young retarded children and their families. These agencies, then, will view the training program as an asset, helping them achieve their own objectives by providing valuable inservice training for their staff.

Using the above considerations and guidelines, the FIT Project had recruited 23 local allied professionals in the three project communities by fall of 1979. Participants included two directors of special education for local school systems, three other educators from special education, head start, and high school child development programs, two school psychologists, a psychologist who is director of a local mental health center, four nurses drawn from a private physicians clinic, a public health office, and a hospital, two regional coordinators for child development services, five members of regional public health child health and development teams, and three social workers and an administrator employed by the community services component of the regional state facility for mentally retarded persons. A systemic survey of these participants at the beginning of the training program revealed that, as a group, they are local professional with substantial experience in their respective fields. Their agencies have a committment to provide services for young mentally retarded children and their families. However, when recruited, the majority of these professionals provided at most a limited range of services to the target population. These trainees, then, do appear to have a good probability, with appropriate training, of increasing the level and range of services they provide.

The inservice training program is quite comprehensive. Based on an analysis of the compentencies required to provide quality educational services, training includes the following content areas: early child development, developmental deviations, and handicapping conditions, educational

programing and curriculum development, diagnostic-perscriptive teaching, parent training, and community liasion. The training includes both didactic and practicum experiences.

Participation in the program requires a substantial commitment of time from participants and their agencies. The program consists of an initial nine months of training in the areas specified above followed by the possibility of further training and supervision as local professionals expand the services they provide to mentally retarded children. The nine month program is offered in four-week cycles consisting of a one half day seminar in the local community, a full day of training activities in Nashville, another half day local seminar, and a half day practicum experience carried out locally. In the seminars, trainees are exposed to relevant theory, technique, and research. They also have an opportunity to carry out observation and intervention projects with the infants and parents in the FIT Project clinic under the supervision of the staff. Full day training activities include tours of services for retarded persons and lectures and workshops on relevant topics by consultants.

Participating professional have found the training program both demanding and rewarding. Attendance has been high and participation enthusiastic. The data compiled for the 18 professionals participating in June, 1979, shows that all trainees attended more than 60% of the scheduled sessions while ten participants attended more than three quarters of all scheduled activities. Since trainees hold fulltime jobs with heavy professional responsibilities, this level of participation strongly suggests that both trainees and their agencies perceive the program as valuable.

The training program was also evaluated through the use of four specially designed instruments. A content evaluation measure has been developed to test trainees knowledge of information covered in the program. It is administered at the beginning and the end of each segment of the training program. Before, and after the program, both trainees and their pro-

ject supervisor rate their professional conpentency in relevant domains. Also, each seminar and training experience is rated on several relevant dimensions. Finally, trainees are asked to describe on a objective questionnaire the level and types of services they provide to the target population. Their responses before and after participation in the program will be compared.

At this early point in the program, only limited data have been collected and analyzed. Nevertheless, some very preliminary results can be mentioned. Participants appear to rate these seminars highly and to learn from them.

The first six persons enrolled attended and rated 17 training seminars through June 1979. They used a five point scale with one defining the unfavorable and five the favorable end of each dimension. The seminars were described as generally useful ($\underline{M}$=4.0), easy to understand ($\underline{M}$=4.1), well organized ($\underline{M}$=4.2), and interesting ($\underline{M}$=4.4). The same group of trainees evidenced significantly increased knowledge on the content measure following participation in the first segment of the nine month training sequence. These preliminary data appear promising. Additional data relevant to evaluating the training program are being collected.

Public Information and Technical Assistance

The FIT Project has adopted a number of stratiges to encourage the development of additional educational services to young, rural mentally retarded children in Middle Tennessee. Descriptions of the project in local print and broadcast media have helped make the public aware of the needs of these youngsters and an approach to helping them. The staff makes frequent presentations to professionals and laymen to keep them informed also. Finally, the staff provides extensive technical assistance to agencies in rural areas to assist them to provide expanded or improved services to young handicapped children and their families. To illistrate, the staff worked with a consortium of local organizations and individuals in Marshall County to mount a county-wide hearing screening program for preschool children.

Conclusions

This paper described the FIT model as it emerged during the initial phases of development and operation. The results so far suggest some very tentative conclusions.

An ecological perspective is a useful guide in building educational services for young mentally children and their families in rural areas. This viewpoint highlights the importance of families and communities, particularly allied professionals, as local resources for the children. The related notions of enhancing the competence and potency of the family and community systems related to the children and of strengthing linkages among them also appear to be fruitfull orientations.

The components of the FIT Project model have been articulated and implemented. The model emerges as a coordinated thrust aiming simultaneously at children and families, the professionals serving them, and the broader community. These three efforts are integrated and mutually supportive. As the model was put into place, the components began to have a catalytic effect upon one another. Elements began to interact and combine in unanticipated ways to advance the work. An atmosphere of excitment developed and became contagious amoung the staff, local professionals, and families. Now, as we approach the conclusion of the project in June, 1981 we are able to see FIT Project services offered on a continuing basis in each project community, supported by various combinations of state, local and private sources. Our confidence in the model is enhanced by the fact that it was accepted and continued by the rural communities themselves.

Acknowledgements

The work described in this chapter was supported by a grant from the Bureau of Education for the Handicapped, U.S. Office of Education (Grant No. G007802932) with matching funds supplied by the Tennessee Department of Mental Health and Mental Retardation. The important contributions to the FIT Project by numerous professionals and organizations in and around Marshall, Dickson, and Warren Counties, Tennessee, are gratfully acknowledged.

The author also wishes to express his gratitude to the staff of the FIT Project for their many contributions. The operational structure of the clinic program was worked out in practice primarly by Ann Ballantine Carr, with the assistance of Maria Donofrio, Myrtle Dianne Smith, and Christine Giordano. Judith A. Davis was responsible for the development and implementation of the allied professional training program. Carl J. Dunst guided the staff in the curriculum area. Valeria Sweeney led the way in initially establishing project sites. Vaughn Stagg directed the program evaluation activities. Secretarial support was provided by Katherine Glass.

The content of this chapter is the responsibility of the author. Opinions expressed herein do not necessarily reflect the position or policy of the U.S. Office of Education and no official endorcement should be inferred.

References

Auerbach, S. Parents learn through discussion. New York: Wiley, 1968.

Bricker, W. A., and Bricker, D. The Infant, Toddler, and Preschool Research and Intervention Project. In T.D. Tjossem (Ed.), Intervention strategies for high risk infants and young children. Baltimore: University Park Press, 1976.

Caplan, G. The family as support system. In G. Caplan and M. Killilea (Eds.), Support systems and mutual help. New York: Grune & Stratton, 1976.

Griffith, R. The abilities of babies. London: University of London Press, 1968.

Hobbs, N. Helping disturbed children: Psychological and ecological strategies. American Psychologist, 1966, 21, 1105-1115.

Holahan, C.J. Social ecology. In I. Iscoe, B.L. Bloom, and C.D. Spielberger (Eds.), Community psychology in transition. New York: Wiley, 1977.

Moroney, R.M. The family and the state. London: Longham, 1976.

Pattison, D.M., Defrancisco, D., Wood, P., Frazier, H., and Crowder, J. A psychosocial kinship model for family therapy. American Journal of Psychiatry, 1975, 132, 1246-1251.

Schein, E.H. Process consultation: Its role in organization development. Reading, Mass.: Addison-Wesley, 1969.

Strauss, B. and Stowe, M.E. How to get things changed. Garden City, N.Y.: Doubleday, 1974.

Thompson, L. Impacting microsystems to develop innovative linkages in rural service delivery networks for developmentally disabled clients. Paper presented at the annual meeting of the American Association on Mental Deficency, Miami Beach, Florida, 1979.

Tjossem, T.D. (Ed.) Intervention strategies for high risk infants and young children. Baltimore: University Park Press, 1976.

Uzgiris, I., and Hunt, J. McV. Assessment in infancy: Ordinal scales of psychological development. Urbana: University of Illinois Press, 1975.